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An Overview of Proposals to Establish an Independent Commission or Board in Medicare

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Summary

Current health care reform discussions have included debates about the merits of creating an independent entity in Medicare to make changes in the program. Currently, Medicare policy is made largely by Congress and, to varying degrees, the Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for administering the program. The proposals being debated would essentially create an independent body of experts with the power to set provider payment rates and make other Medicare policy decisions.

Advocates of these types of proposals argue that creating a new independent entity or governance structure in Medicare is necessary if we hope to achieve any real health care reform, particularly reductions in overall spending. According to supporters, members of Congress are easily influenced by special interests and lobbyists when developing Medicare policies, particularly those related to provider reimbursement. As a result, some of the decisions that are made may not be fiscally sustainable or in the best interest of beneficiaries. Additionally, proponents argue that members do not have the technical expertise or professional experience required to manage a health insurance program as complex as Medicare. They contend that the public would be better served by having independent experts, insulated from political pressures, responsible for making Medicare policy.

Opponents of these proposals express concern about reducing Congress's role in the Medicare policymaking and oversight process. Under the proposals being discussed, recommendations made by the new commission or decision-making entity would automatically become law without congressional action. Critics contend that giving too much power to an entity composed of unelected officials would reduce its accountability to Congress and the public.

Over the past year, several proposals have been introduced by Congress to create a new administrative or governing structure in Medicare. On June 25, 2009, Senator Jay Rockefeller introduced S. 1380, the Medicare Payment Advisory Commission (MedPAC) Reform Act of 2009, which would elevate MedPAC, a congressional advisory commission, to an executive branch agency. The Obama Administration submitted a similar proposal to Congress titled the Independent Medicare Advisory Council Act (IMAC) on July 17, 2009. The Administration's draft proposal would create an independent five-member executive council to make recommendations to the President. Finally, the Senate Finance Committee included a provision establishing an independent Medicare advisory board in its health reform legislation, the Patient Protection and Affordable Care Act (H.R. 3590), which passed the Senate on December 24, 2009. All proposals would transfer certain Medicare oversight and decision-making responsibilities to an independent, policymaking entity.

This report introduces readers to the concept of creating an independent, policymaking entity in Medicare. The report begins with a discussion of the types of policymaking entities that have been proposed in the current health care reform debate, as well as in Medicare. The report then provides an overview of the role that Congress and CMS play in determining Medicare policy. The report concludes with a comparison of some of the key features of S. 1380, the Administration's draft IMAC proposal, and H.R. 3590.

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Introduction

As the debate surrounding health care reform continues, there has been considerable discussion about creating a new, independent entity to determine Medicare policy. Currently, Medicare policy is made largely by Congress and, to varying degrees, the Centers for Medicare and Medicaid Services (CMS). CMS, housed within the Department of Health and Human Services (DHHS), is the federal agency responsible for administering the Medicare, Medicaid, and Children's Health Insurance (CHIP) programs. The proposals being debated would essentially create an independent body of health care experts with the power to make fundamental decisions affecting Medicare.

Advocates of these types of proposals argue that creating an independent, policymaking entity in Medicare is necessary if we hope to achieve any real health care reform. Supporters claim that members of Congress are easily influenced by special interests and lobbyists when making Medicare policy decisions, particularly those related to provider reimbursement. As a result, some of the decisions that are made may not be fiscally sustainable or in the best interest of beneficiaries. Advocates also contend that lawmakers do not have the necessary technical or operational expertise required to govern a program as complex as Medicare. Every year lawmakers, many of whom have limited experience in health care financing or delivery, make detailed operational decisions related to Medicare's provider payment systems. The perception, at least by some, is that an independent body of experts, insulated from politics, would produce more fiscally responsible and efficient policy decisions.

Opponents of these proposals express concern about reducing Congress's role in the policymaking and oversight process. The proposals being discussed would establish a new policymaking body with the authority to make changes in the program without congressional approval. By delegating certain lawmaking functions to an independent entity, Congress would be ceding some of its oversight responsibilities. For example, today, when it examines the merits of a particular policy, Congress can hold hearings and debates, both of which are open to the public. Although these proposals include certain oversight mechanisms, such as annual reports and studies, the day-to-day deliberations of the new entity or council would not necessarily be available to the public.

On June 25, 2009, Senator Jay Rockefeller introduced S. 1380, the Medicare Payment Advisory Commission (MedPAC) Reform Act of 2009, which would elevate MedPAC, a congressional advisory commission, to an executive branch agency with the authority to determine Medicare payment and coverage policies. The Obama administration submitted a similar proposal to Congress, titled the Independent Medicare Advisory Council Act (IMAC) of 2009, on July 17, 2009.[1] The Administration's proposal would create an independent five-member executive council charged with issuing recommendations on Medicare payment policy to the President. Finally, the Senate Finance Committee included a provision to establish an independent Medicare advisory board in its health reform legislation, the Patient Protection and Affordable Care Act (H.R. 3590), which passed the Senate on December 24, 2009. Although different in structure and scope, all of these proposals would alter the role Congress has traditionally played in the Medicare policymaking process.

This report introduces readers to the concept of creating an independent, policymaking entity in Medicare. The report begins with a discussion of the types of policymaking entities that have been proposed in the current health care reform debate, as well as in Medicare. The report then

[1] The Independent Medicare Advisory Council Act can be accessed at http://www.whitehouse.gov/omb/assets/legislative_letters/IMAC_bill_071709.pdf.

provides an overview of the role that Congress and CMS play in determining Medicare policy. The report concludes with a comparison of some of the key features of S. 1380, the Administration's draft IMAC proposal, and H.R. 3590.

Background

The current health care reform debate has included discussions about creating new independent entities to conduct certain administrative and policymaking functions in the health care system. In addition to proposals to establish this type of entity in Medicare, the concept has been offered as a tool for performing research on comparative effectiveness, managing the private health insurance market, making payment and coverage decisions, and proposing broader reforms to the health care system. At least one of the rationales for creating independent entities with policymaking authority is the assumption that, because these organizations are insulated from both the congressional and executive decision-making processes, they can make better policy decisions.

Independent entities typically share certain characteristics. First, they are usually governed by boards or commissions composed of members who are appointed by the President and confirmed by the Senate. Representatives are usually appointed for long, fixed terms to reduce the likelihood that they will be influenced by either the White House or congressional politics. Additionally, terms are usually staggered to ensure that not all of the members are appointed during one presidential administration. Other features associated with independence include requiring the President to consider political orientation when appointing members and mandating that the membership represent a diverse mix of professional experience or expertise.

One prominent model of an independent health care entity discussed throughout the current reform debate is the Federal Health Board. Endorsed by former Senator Tom Daschle, a Federal Health Board would be modeled after the Federal Reserve Board and have broad authority over private and public health care programs. The Federal Reserve, which establishes the nation's monetary policy, is composed of a national Board of Governors consisting of seven members and 12 regional banks.[2] The Board of Governors has significant authority to oversee and regulate the banking system. As envisioned by Daschle and others, a Federal Health Board would play a substantial role in making benefit and coverage recommendations, regulating the private health insurance market, conducting research, and improving the quality of care.[3]

Some of the other models that have been discussed are more modest in scope. For example, in addition to including a provision establishing a Medicare advisory board, H.R. 3590 would establish a private, non-profit corporation titled the Patient-Centered Outcomes Research Institute to conduct comparative clinical effectiveness research. The corporation, which would be overseen by a Board of Governors composed of 17 members appointed by the Comptroller General, would be charged with identifying national priorities for performing comparative effectiveness research and contracting with public and private organizations to conduct such research. Another proposal would create an organization or entity to oversee the market for private health insurance. These entities, which are referred to as health insurance exchanges, would be responsible for

[2] For additional information on the design and structure of the nation's Federal Reserve System, see the Federal Reserve System: Purposes and Functions, available at http://www.federalreserve.gov/pf/pdf/pf_complete.pdf.

[3] Tom Daschle, Scott S. Greenberger, and Jeanne M. Lambrew, *Critical: What We Can Do About the Health-care Crisis* (St. Martin's Press, 2008).

establishing and enforcing standards for private health plans related to benefits, coverage, enrollment, and beneficiary cost-sharing.[4]

Proposals to establish an independent entity in Medicare also vary in scope and structure. Some measures would create an independent commission, board, or entity with the authority to determine specific Medicare policies, particularly those related to provider reimbursement and benefit coverage. Others would create a governance structure with a broader scope of authority. For example, in a recent paper for the New America Foundation on reforming Medicare's governance, certain health experts advocate creating a new independent board called the Medicare Guardians. Under this proposal, the Medicare Guardians would function like a board of directors for Medicare with broad authority to enact policies directed at restructuring how the program pays for and delivers health care.[5]

Congress has debated the merits of creating a new administrative entity in Medicare several times throughout the program's history, most recently in the Medicare reform discussions of 2000 and 2001. At that time, Congress was considering adding a new prescription drug benefit to the program and exploring options to foster competition among private Medicare plans. However, there were concerns that CMS (at that time the Health Care Financing Administration, or HCFA), already overwhelmed with new responsibilities, would not be able to manage an increase in its workload.[6] Various reform proposals recommended a number of solutions to rectify the agency's management problems, including expanding its authority to perform its responsibilities, increasing the agency's annual budget, creating separate agencies to administer parts of the program, and establishing a Medicare Board to manage competition among private plans and traditional Medicare.[7]

Overview of the Medicare Policymaking Process

Currently, Medicare policy is determined largely by Congress and the three congressional committees that have jurisdiction over the program: the House Committee on Ways and Means, the House Committee on Energy and Commerce, and the Senate Committee on Finance.[8] These committees regularly propose and draft legislation to modify all aspects of the Medicare program, including payment policy, benefits, coverage, and program administration. In some areas, Congress has created legislative language that is very detailed and prescriptive. For example,

[4] H.R. 3962 includes a proposal to establish an independent federal entity to oversee the private market for health insurance. For additional information, see CRS Report R40885, *Private Health Insurance Provisions of H.R. 3962*.

[5] See *Making Medicare Sustainable* by Len Nichols and Robert Berenson for the New America Foundation, available at http://www.newamerica.net/files/MakingMedicareSustainable.pdf.

[6] In an open letter to Congress and the executive branch, published in the January/February 1999 issue of Health Affairs, a group of health policy experts attributed HCFA's difficulties to micromanagement of the agency by Congress, lack of administrative flexibility, and limited resources. See "Crisis Facing HCFA and Millions of Americans," available at http://content.healthaffairs.org/cgi/reprint/18/1/8.pdf.

[7] Two of the more widely discussed approaches were the Breaux-Frist I and II proposals. Under Breaux-Frist I, a Medicare Board, housed within the executive branch, would have been created to manage competition among private Medicare plans and the traditional fee-for-service (FFS) program. The board would have been responsible for negotiating premiums with private plans and approving benefit packages, a function now performed by CMS for the Medicare Advantage program. Breaux-Frist II proposed creating a new Medicare agency responsible for overseeing the Medicare+Choice (Medicare Advantage's predecessor program) and prescription drug benefit programs.

[8] In the House, the Committee on Ways and Means has jurisdiction over Medicare Part A, and the Committee on Energy and Commerce has jurisdiction over Medicare Part B. In the House, the Senate Finance Committee has jurisdiction over the Medicare program in its entirety.

policymakers have established sophisticated payment systems and methodologies for reimbursing providers participating in Medicare Parts A and B.[9] Congress has also mandated specific criteria for benefit coverage (i.e., beneficiary co-insurance and cost sharing amounts, day limits on coverage, and patient eligibility requirements).[10]

In other areas, congressional involvement in Medicare policy is less developed. For example, although Congress has outlined broad benefit categories for Medicare coverage in Title XVIII of the Social Security Act (SSA), it has given CMS substantial discretion and flexibility to make individual coverage determinations.[11] CMS executes this authority by implementing both national and local coverage determinations, otherwise known as NCDs and LCDs. NCDs and LCDs grant, limit, or exclude Medicare coverage for a specific medical service, procedure, or device. To date, CMS has issued approximately 308 NCDs.[12] The vast majority of Medicare coverage decisions, however, are LCDs, which are made at the local level by private contractors.

To assist with its policymaking efforts, Congress relies on the analytic and research support of its legislative branch agencies: the Congressional Budget Office (CBO), the Congressional Research Service (CRS), the Government Accountability Office (GAO), and the 17-member Medicare Payment Advisory Commission, otherwise known as MedPAC. Congress established MedPAC with the Balanced Budget Act of 1997 (P.L. 105-33).[13] Specifically, Congress charged the commission with reviewing and making recommendations to Congress regarding Medicare payment policies, including payments to private Medicare+Choice health plans (now called Medicare Advantage plans).

The statute also requires the commission to examine other issues affecting the Medicare program, such as changes in the health care delivery system, changes in the market for health care services, Medicare payment policies and their relationship to quality and access, and factors affecting the efficient delivery of health care services in different sectors (e.g., hospitals, skilled nursing facilities).

The commission issues the majority of its policy recommendations through two annual reports to Congress: a March report on Medicare payment policy and a June report on other policy issues affecting the Medicare program. The types of recommendations range from broad, long-term policies such as implementing pay for performance and quality measurement programs to detailed payment update recommendations for Medicare's fee-for-service (FFS) providers.[14] When formulating its recommendations, the commission takes into account the adequacy of current provider payments and the efficiency of providers. For example, in its March 2009 report, the

[9] For a detailed description of Medicare's payment policies, see CRS Report RL30526, *Medicare Payment Policies*.

[10] For more information on the specifics of Medicare payment and benefit policies, see CRS Report R40425, *Medicare Primer*.

[11] Social Security Act (SSA) Section 1862(a) (1). Generally, in order to be covered by Medicare, a service must fall within a defined Medicare benefit category, be reasonable and necessary for the individual, and not be statutorily excluded from coverage. The statute vests broad authority with the Secretary to determine what constitutes "medically reasonable and necessary."

[12] To access a list of Medicare's NCDs and LCDs, see the CMS website at http://www.cms.hhs.gov/center/coverage.asp.

[13] MedPAC is authorized under Section 1805 of the SSA. The Commission is composed of 17 members appointed for three-year terms by the Comptroller General of the Government Accountability Office (GAO).

[14] In its annual March report, MedPAC recommends how much Medicare payments to providers should be increased or decreased for the coming year. These amounts are referred to as payment updates. When making its payment update recommendations, the commission takes into account the adequacy of the payment, any policy changes expected to take effect in the coming year, and any projected changes in provider costs.

commission recommended eliminating or reducing payment updates for skilled nursing facilities, home health services, and inpatient rehabilitation facilities in FY2010. The commission also testifies regularly for various congressional committees on its findings and recommendations.

In establishing MedPAC, Congress merged two previous Medicare advisory commissions: the Prospective Payment Assessment Commission (ProPAC) and the Physician Payment Review Commission (PPRC). Congress created ProPAC in 1983 to provide guidance on implementing the hospital prospective payment system and the PPRC in 1985 to make recommendations to Congress on reforming Medicare's physician payment system. ProPAC and PPRC were established, at least in part, because Congress had become increasingly distrustful of the executive branch and HCFA.[15] By creating an independent advisory body to assist lawmakers in their policymaking efforts, Congress was able to obtain its own source of objective expertise on Medicare payment policy and buffer members of Congress from pressures from interest groups.

MedPAC, like its predecessor agencies, does not have the authority to actually implement its recommendations without congressional approval or regulatory action by CMS. Although the actual number of MedPAC recommendations implemented by Congress is difficult to measure, the perception is that the commission has been relatively influential in shaping Medicare policy. According to the commission's FY2010 budget request, MedPAC assesses its impact on the policymaking process by publicly reporting its outputs (e.g., number of requests for information from Congress, number of policy briefs published, and number of testimonies) and qualitatively describing the outcomes of its recommendations.

Characteristics of Proposals to Establish an Independent Entity in Medicare

On June 25, 2009, Senator Rockefeller introduced S. 1380, the Medicare Payment Advisory Commission (MedPAC) Reform Act of 2009. S. 1380 would establish the MedPAC as an executive branch agency with broad policymaking authority in the areas of Medicare payment and coverage.[16] July 17, 2009, the President submitted a draft proposal to Congress titled the Independent Medicare Advisory Council Act of 2009, otherwise known as the IMAC proposal. The IMAC proposal would establish a five-member council to advise the President on Medicare payment rates for certain providers. Although the proposal provides the council with the authority to recommend broader policy reforms, its authority outside of Medicare payment policy would be limited. Finally, the Senate Finance Committee included a provision (Sec. 3403) to establish an independent Medicare advisory board in its health reform legislation, the Patient Protection and Affordable Care Act (H.R. 3590). Under this option, an independent board would be required to develop and submit detailed proposals to Congress and the President to reduce Medicare spending. In the sections that follow, more detailed information comparing these proposals across key categories such as membership, scope of authority, presidential and congressional review procedures, cost control mechanisms, and funding are presented. See **Table 1** for highlights from these sections.

[15] Rick Mayes, Ph.D. and Robert A. Berenson, M.D., *Medicare Prospective Payment and the Shaping of U.S. Health Care* (The Johns Hopkins University Press, 2006), p. 57.

[16] Specifically, the new MedPAC Commission would be charged with three primary responsibilities: (1) determining Medicare reimbursement policy, (2) determining Medicare coverage policies, including National Coverage Determinations (NCDs), and (3) improving the overall financial stability of the Medicare program through its payment and coverage policies.

Membership

All three proposals would create an independent entity composed of members appointed by the President, with the advice and consent of the Senate. S. 1380, however, would replace the current 17-member MedPAC advisory commission with an 11-member executive commission, essentially elevating MedPAC to an executive branch agency. This is in contrast to the Administration's proposal that would create a new five-member executive council, and H.R. 3590, which would establish a new 15-member independent Medicare advisory board.

Members would serve staggered six-year terms in S. 1380 and H.R. 3590, and five-year terms under the Administration's proposal. Under all three options, the President, with the advice and consent of the Senate, would appoint a Chair for the entity from among its members.[17] H.R. 3590 includes an additional requirement that the Senate Majority Leader, Speaker of the House, Senate Minority Leader, and House Minority Leader each present three recommendations for appointees to the President for his consideration. The Secretary, the Administrator of CMS, and the Administrator of the Health Resources and Services Administration (HRSA) would serve as ex-officio, non-voting members of the Board.

For the entities that would be established by S. 1380 and H.R. 3590, qualifications for membership would be the same or similar to those currently authorized for MedPAC.[18] The only qualifications for membership stipulated in the Administration's proposal are that appointees be physicians or have specialized expertise in medicine or health care policy.

Scope of Authority

All three proposals would provide a new independent entity with the explicit authority to make decisions related to provider payment. S. 1380, however, is the only proposal to provide the Commission with the authority to make Medicare coverage decisions. Under all three proposals, CMS would retain its responsibility for issuing regulations to implement the entity's recommendations.[19]

S. 1380 would elevate MedPAC from a legislative advisory body to an executive branch agency and provide the new commission with broad authority in the areas of Medicare payment and coverage. The Commission would be responsible for developing payment policies, methodologies, and reimbursement rates (including payment updates) for all Medicare providers and suppliers. The Commission would also be responsible for developing Medicare coverage

[17] For additional information on the Presidential appointment process, see CRS Report RL34744, *Presidential Appointments to Full-Time Positions on Regulatory and Other Collegial Boards and Commissions, 109th Congress*, by Henry B. Hogue et al.

[18] H.R. 3590 requires that members of the Board include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, other providers of health care services and other related fields. Members are to represent a mix of different professions, geography, and urban and rural communities. Membership is also required to include (but not be limited to) physicians and other health care professionals, experts in the area of pharmaco-economics or prescription drug benefit programs, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research, expertise in outcomes and effectiveness research and technology assessment, and consumer and elderly representatives. The statue prohibits health care providers from constituting a majority of the commission's membership.

[19] To implement Medicare policy, CMS administrators promulgate rules and regulations based on the statutory requirements mandated by Congress. When issuing regulations, CMS is required to follow federal "notice and comment" rulemaking procedures, which essentially mandate that proposed rules be published in the *Federal Register* and that the public be given 30-days to respond.

policy, a function currently executed by CMS and its private contractors. To assist in its policymaking functions, S. 1380 requires that the Commission establish three advisory councils: a Council of Health and Economic Advisors, a Consumer Advisory Council, and a Federal Health Advisory Council.

The Administration's proposal would establish a separate independent entity with a narrower scope of authority. The IMAC's primary responsibility would be recommending annual payment updates for certain Medicare providers. Although the proposal provides the Council with the authority to recommend broader Medicare reforms, the legislation specifies many exceptions to this authority. Among these are recommendations relating to Medicare financing, capital payments to inpatient hospitals, certain Medicare administrative activities such as claims processing and fraud control, conditions of participation, and physician and hospital quality reporting. The proposal does not explicitly exclude Medicare coverage policy from the Council's jurisdiction.

The Independent Medicare Advisory Board established by H.R. 3590 would have the authority to develop and submit recommendations, in certain years, to Congress and the President to reduce Medicare spending.[20] The provision lays out specific criteria for the Board to meet when making its recommendations. For example, when developing and submitting proposals, the Board would be required to develop recommendations that would reduce spending in Medicare Parts C and D;[21] prioritize recommendations that would extend Medicare solvency; improve the health care delivery system and health outcomes by promoting integrated care, care coordination, prevention, wellness, and quality improvement; protect beneficiary access to care (including in rural and frontier areas); and consider the effects of changes in provider and supplier payments on beneficiaries.

H.R. 3590 also clearly exempts certain areas from the Board's authority. Specifically, the Board would be prohibited from making recommendations that would ration care, raise revenues, increase beneficiary premiums, increase beneficiary cost-sharing, restrict benefits, or modify eligibility. Additionally, prior to 2020, the Board could not make any recommendation that would reduce payments to providers and suppliers scheduled to receive a reduction in their payment updates in excess of a reduction due to productivity (i.e., hospitals and physicians).

Presidential Review Procedures

The Administration's proposal is the only proposal of the three that requires explicit presidential approval or disapproval of the Council's recommendations. Specifically, the Administration's proposal would require that the Council submit two annual reports to the President containing its recommendations for payment updates to Medicare providers. The President would have 30 days to approve or disapprove of the Council's report in its entirety. The President would not have the authority to disapprove individual recommendations.

[20] The law specifies a trigger for when the Board would be required to submit a proposal to Congress. For years 2014 through 2017, the Board would only be required to submit a proposal when Medicare spending per beneficiary exceeds the average of the annual rates of growth in the Consumer Price Index (CPI) and the CPI-M for medical care. Beginning in 2018, the Board would be required to submit proposals only in years when Medicare spending per beneficiary is projected to exceed the rate of growth in the GDP plus 1 percentage point.

[21] In accordance with the statute, the Board could reduce spending in Parts C and D by reducing Medicare payments for administrative expenses to MA and PDP plans, denying or removing high bids for drug coverage from the calculation of the monthly bid amount for Part D plans, and reducing performance bonuses for MA plans. Recommendations could not affect the base beneficiary premium percentage or the full premium subsidy for Part D plans.

H.R. 3590 requires the transmission of the Independent Medicare Advisory Board's proposals to the President but does not stipulate specific procedures for the President to review and comment on the Board's recommendations. However, the Board would be required to submit a copy of the proposal to the Secretary for the Secretary's review and comment. Further, if the Board fails to submit a proposal to the President and Congress by January 15, the Secretary would be required to submit a contingent proposal, meeting the same fiscal policy requirements.

Congressional Review Procedures

Under all three options, the Commission or Board's recommendations would automatically go into effect without congressional action. Congress would need to pass legislation that would either supersede the entity's recommendations or block their implementation. Each proposal specifies different procedures for Congress to follow to initiate this process. For example, under S. 1380, Congress would need a three-fifths majority in the House or Senate (67 in the Senate or 290 in the House) to consider a measure that would overrule a payment or coverage determination made by the Commission.

To prevent the implementation of recommendations proposed by the IMAC, the Administration's proposal would require that Congress enact a joint resolution of disapproval within 30 days from the date the President approves the Council's recommendations. All joint resolutions of disapproval are required to be approved and signed by the President. Given that the IMAC proposal would require presidential approval of the Council's recommendations, it is unlikely that the President would then approve a congressional resolution to nullify those recommendations. To prevent the proposal from becoming law, Congress would then need two-thirds majorities in both Houses of Congress to override the President's veto of the resolution.

H.R. 3590 is the only proposal that includes expedited or "fast track" procedures for congressional consideration of the Board's recommendations. Expedited procedures help ensure that Congress take action on particular legislation that might otherwise never make it out of committee. Under this option, the Board would be required to submit its annual recommendations to Congress and the President by January 15. By April 1, the Senate Finance Committee, the Committee on Ways and Means, and the Committee on Energy and Commerce would be required to report out either the Board's proposal or an amended version of the proposal or be discharged from further consideration of the proposal. If Congress does not enact legislation that supersedes the Board's proposal by August 15, the Secretary would be required to automatically implement the Board's proposal, subject to certain conditions.[22] To discontinue the automatic implementation of the Board's recommendations beyond 2019, Congress would have to pass a joint resolution of disapproval no later than August 15, 2017.

Timeline for Recommendations

S. 1380 would require that the Commission propose its first set of payment recommendations by December 1, 2012, for implementation beginning in 2013. Under the Administration's proposal and H.R. 3590, the first set of recommendations would be required in 2014 for implementation in 2015.

[22] For years 2019 and beyond, the Secretary would not be required to implement the Commission's recommendations if the rate of growth in National Health Expenditures (NHE) exceeds the rate of growth in Medicare spending.

Cost Control Mechanisms

All proposals contain mechanisms designed to control spending in the Medicare program. Under S. 1380, the new MedPAC Commission would be required to reduce Medicare expenditures by at least 1.5% annually. If the Chief Actuary of CMS concludes that the Commission's policies would not reduce expenditures by this amount, the Secretary would be required to implement an automatic reduction in payment to Medicare providers and suppliers to achieve the 1.5% savings, subject to certain requirements.

H.R. 3590 specifies annual savings targets that the Board would be required to meet. Specifically, the Board would be required to develop recommendations that would reduce projected Medicare spending by the lesser of 0.5 percentage points in 2015, 1.0 percentage points in 2016, 1.25 percentage points in 2017, and 1.5 percentage points in years 2018 and beyond, and the amount by which the rate of growth in Medicare spending exceeds a rate of inflation (as defined in statute). The bill also includes a budget neutrality provision. The Board's recommendations could not increase Medicare expenditures, over the next 10-year period, over and above what they would have been without the recommendations. In its estimate of the Patient Protection and Affordable Care Act released on December 19, the Congressional Budget Office (CBO) predicted that the provision would reduce Medicare spending by $28.2 billion between years 2015-2019, taking into account reductions anticipated for other provisions in the legislation.[23]

The Administration's proposal also includes a 10-year budget neutrality provision. Proposals that did not meet this budget neutrality requirement could not be implemented. The CBO analysis of the President's IMAC proposal estimated minor savings from the proposal, $2 billion in savings over 2010-2019 with all of the savings realized in fiscal years 2016 through 2019. To achieve larger savings, the agency recommended including explicit targets for reductions in spending, similar to S. 1380 and H.R. 3590, as well as providing the Council with broader authority to make other changes in the program.

Funding for Activities

Both S. 1380 and the Administration's proposal would authorize funding, in such sums as necessary, for the Commission or Council's activities. Sixty percent of the appropriation would be payable from the Medicare Part A Trust Fund and 40% from the Part B Trust Fund. H.R. 3590 would appropriate $15 million for the Board's activities beginning in 2012. This amount would increase by the rate of inflation annually thereafter.

[23] The CBO analysis is available at http://cbo.gov/ftpdocs/108xx/doc10868/12-19-Reid_Letter_Managers_Correction_Noted.pdf.

Table 1. Summary of Key Characteristics of Proposals to Establish an Independent Commission or Entity in Medicare

	The Patient Protection and Affordable Care Act as passed by the Senate (H.R. 3590)	The Medicare Payment Advisory Commission Reform Act (S. 1380, as introduced)	President's Proposal to Establish an Independent Medicare Advisory Council (IMAC)
Membership	15 members appointed by the President with the advice and consent of the Senate	11 members appointed by the President with the advice and consent of the Senate	5 members appointed by the President with the advice and consent of the Senate
- Length of Terms	6 years; staggered	6 years; staggered	5 years
- Qualifications	Similar to MedPAC	MedPAC qualifications	Physicians or expertise in medicine or health care policy
Scope of Authority	Authority to recommend policies to reduce Medicare spending by targeted amounts, subject to strict fiscal and policy criteria (i.e. proposals could not target certain providers). Proposals could not ration care, raise revenues, increase beneficiary cost-sharing, restrict benefits, or modify eligibility	Broad authority in Medicare payment and coverage policy, including determining Medicare payment rates for providers and making national coverage determinations	Reduced scope of authority to recommend payment updates for certain Medicare providers; provides authority to recommend broader reforms, but subject to numerous exceptions
Presidential Review	No requirement for presidential review	No requirement for presidential review	Recommendations are submitted as a package to the President; President would have 30 days to approve or disapprove of the package
Congressional Review	Includes expedited or "fast track" procedures for Congressional consideration; Congress would have 90 days to review the Commission's proposals; if no law is enacted the Commission's proposal would automatically go into effect by August 15th	Congress would need a 3/5 majority in the House or Senate (67 in the Senate or 290 in the House) to consider a measure that would overrule a payment or coverage determination made by the Commission	Recommendations would automatically go into effect 30 days from President's approval unless Congress enacts a joint resolution of disapproval

	The Patient Protection and Affordable Care Act as passed by the Senate (H.R. 3590)	The Medicare Payment Advisory Commission Reform Act (S. 1380, as introduced)	President's Proposal to Establish an Independent Medicare Advisory Council (IMAC)
Cost Control Mechanisms	Proposals would be required to achieve annual targeted reductions in Medicare spending; however, the Board is only required to submit proposals to Congress in years where Medicare spending exceeds a target growth rate; recommendations must be budget neutral over a 10-year period	Policies would be required to reduce Medicare expenditures by 1.5%	Recommendations must be budget neutral over a 10-year period
First Year Entity's Policies Would Take Effect	2015; Congress would have to pass a joint resolution to terminate the Commission's activities in 2017 for implementation years beginning in 2020	2012	2015
Funding	Appropriates $15 million beginning in FY2012 for the Board's activities; appropriation increases by rate of inflation annually thereafter	Annual congressional appropriations	Annual congressional appropriations

Source: CRS analysis of proposals to create an independent governing entity in the Patient Protection and Affordable Care Act (H.R. 3590), the Medicare Payment Advisory Commission or MedPAC Reform Act of 2009 (S. 1380), and the Obama Administration's draft bill titled the Independent Medicare Advisory Council Act (IMAC).

Concluding Observations

In the current health care reform debate, the idea of creating an independent, policymaking entity in Medicare has gained prominence. This report illustrates some of the key characteristics for three of the legislative options that have been proposed. Although not a new concept, the idea of creating an independent commission or governing entity in Medicare has garnered attention in recent months because it is perceived as a viable approach for containing health care spending. However, as this comparison demonstrates, determining the appropriate size, scope of authority, cost control mechanisms, and level of independence for a new policymaking body presents challenges for lawmakers and health care experts. As policymakers continue to debate options for health reform, examining and assessing the various approaches for creating these types of entities will become increasingly important.

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